

Medico-legal issues in anaesthesia

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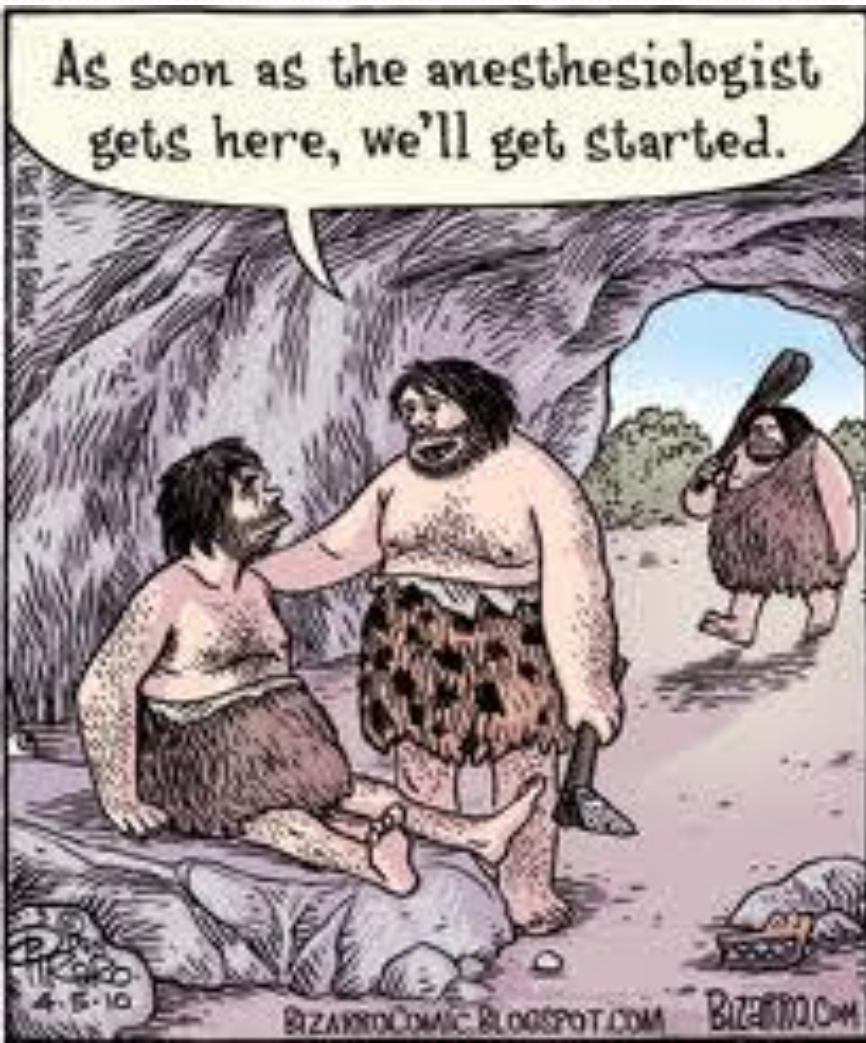


INTRODUCTION

“MAN CAN BUT ACHIEVE TRANSITORY SLEEP
WHILE LORD CAN PUT HIM TO ETERNAL SLEEP”
-Dr. Graham pearce.

- New technologies and extended roles in practice of medicine undoubtedly creates new interfaces between medicine and law.
- Anaesthesia and the practice of pain management is therefore not wholly protected against medical negligence.
- Negligence touching on the role of pain nurse-paucity of information. Same rule applies.

Anaesthesia and pain control in practice



Current NHS Litigation Statistics

- 8655 claims of clinical negligence reported in England in 2010–11 compared with 6652 the previous year.
- The NHS budget for 2010/11 was around £104 billion.
- The NHS LA paid out £729.1 million in damages and £235 million in legal costs.
- The cost of damages therefore represents 0.7% of the NHS budget and legal costs 0.2%.
- The number of files opened each year by the Medical Protection Society (MPS) for anaesthetists (including those practising in critical care and pain) has increased steadily over the last 10 yr, with more than 300 new files opened in 2011.

Stats

- Around one in eight of these new files will be negligence claims against anaesthetists in private practice
- Serious complications associated with general anaesthetics are very rare, occurring in less than one case for every 10,000 anaesthetics given.
- Death – this is rare, approximately one death occurs for every 100,000 general anaesthetics given, according to NHS statistics.
- Despite the rising tide of litigation, the chance of any practising anaesthetist facing a civil claim over a professional lifetime remains small

Why do patients Litigate

- Compensation
- Compensation
- Compensation

Civil v Criminal litigation

- Majority of CN litigation proceed along the civil litigation pathway
- However, the death of a patient may lead to criminal manslaughter charges.
- The key elements required are the same as for a civil negligence case: a duty of care, a breach of that duty of care amounting to gross negligence, and causation.

Anaesthetist whose error killed a 14 year old was jailed for 6 months. The child suffocated when nitrous oxide was given instead of oxygen



Headline

The Law of Negligence in General

- Negligence is an act or omission which falls below the standard to be expected of a reasonably competent doctor in a particular field.
- What are the Elements of Negligence and how can it be proven?
- What does this all mean and how easy is it to sue a practitioner?

Science and Law

- Scientific proof = 95% probability
- Legal proof = 51% probability – “a balance of probabilities”

Duty Of Care

- Presumption that this duty exists
- Established by *Donoghue v. Stevenson* [1932]
 - The claimant, May Donoghue, drank ginger beer given to her by a friend, who bought it from a shop. The beer was supplied by a manufacturer, a certain David Stevenson in Scotland. While drinking the drink, Donoghue discovered the remains of an allegedly decomposed slug. She then sued Stevenson, though there was no relationship of contract, as the friend had made the payment. As there was no contract the doctrine of privity prevented a direct action against Stevenson.

Duty Of Care

More Recently in England:

- The case of *Caparo v Dickman* [1990] introduced a 'threefold test' for a duty of care. Harm must be:
 - (1) reasonably foreseeable
 - (2) there must be a relationship of proximity between the plaintiff and defendant and
 - (3) It must be 'fair, just and reasonable' to impose liability.

Bolam test

- “A doctor/nurse is not negligent if he or she is acting in accordance with a practice accepted as PROPER by responsible body of medical men skilled in that art even though other doctors adopt a different practice”.
- Therefore if the defendants can show that the nurse or doctor acted in accordance with a reasonable body of opinion, they will have a defense to the claim. Practitioners refer to the 10% rule. It is said that if 10% of the doctors in the country would have taken the same course of action then it will not be a negligent act.

Breach Of Duty

- An act, omission or practice of a medical professional will be found to be sub-standard or negligent, where it constitutes a departure from a body of responsible medical opinion in the relevant discipline at the time.
- It follows therefore that a doctor can successfully defend a claim if they can show a reasonable or responsible group of doctors would have acted in the same way i.e. provided the treatment in the same way. This group of doctors need not necessarily be a majority group.
- However, any act, omissions or practice of the doctor in question must have a logical basis, taking into account the comparative risks and benefits of the treatment in question. **Bolitho v City and Hackney Health Authority**

Breach Of Duty

- **Bolitho v City and Hackney Health Authority**

- A 2 year old child was admitted to hospital suffering from breathing difficulties. A doctor was summoned but did not attend as her bleep was not working due to low battery. The child died. The child's mother brought an action claiming that the doctor should have attended and intubated the child which would have saved the child's life. The doctor gave evidence that had she attended she would not have intubated. Another doctor gave evidence that they would not have intubated. The trial judge applied the Bolam test and held that there was no breach of duty. The claimant appealed.

Held:

In applying the Bolam test where evidence is given that other practitioners would have adopted the method employed by the defendant, it must be demonstrated that the method was based on logic and was defensible.

Criticisms of Bolam Test

- Too protective of doctors
- Judges not permitted to choose between competing expert views
- “Responsible body” not defined
- A sociological rather than a normative framework

Limits on the Bolam Test

There are a number of reported cases, which suggest limits on the *Bolam* test. In *Hucks v Cole* (1968) 118 NLJ 469, Lord Denning MR said:

- *A doctor is not to be held negligent simply because something has gone wrong.*
- *He is not liable for mischance or misadventure or for an error of judgment.*
- *He is not liable for taking one choice out of two or favouring one school rather than another.*
- *He is only liable when he falls below the standard of a reasonably competent practitioner in his field. On such occasions, the fact that other practitioners would have done the same thing as the defendant is a very weighty matter to be put in the scales on his behalf; but it is not conclusive.*
- *The court must be ever vigilant to see whether the reasons for putting a patient at risk are valid in the light of any well known advance to out of date ideas.*

Limits on the Bolam Test

In *Hunter v Hanley* 1955 SLT 213,

- it was stated that in the realms of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men: ‘... the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care’.
- This approach must be considered with some caution, as each case will turn on its own facts.

Causation

- If breach of duty/negligence can be established, a Claimant must then go on to prove that the negligence/breach of duty in question has caused or materially contributed to an injury or loss, which they would not otherwise have sustained, with correct or proper treatment.

Chester v Afshar

- Significantly change the medico-legal landscape in favour of the claimant
- Up until this case it has been quite difficult to sue a practitioner
- refined the expected standard of consent from that which the doctor considered reasonable to disclose to that which the patient wished to know or should reasonably have known
- this specific case has implications for all practising anaesthetists and pain management teams, particularly when undertaking invasive interventions.

Questions that may suggest that a practitioner is negligent

- Is the procedure or course of action taken by the nurse or doctor out of date, taking into consideration what the acceptable procedure was at the time of the alleged breach?
- If not, would other nurses or doctors in that particular field carry out the same procedure or taken the same course of action?
- If so, has the nurse or doctor in question performed the procedure or taken a course of action to the standard of a reasonably competent doctor skilled in that particular procedure or course of action?
- Finally is the procedure or course of action so complicated that it requires referral to an expert skilled in that procedure or course of action?

Negligent adverse events related to anaesthesia

Failure to achieve goals of a GA or regional technique including:

- Pain during a procedure under regional techniques
- Awareness
- Unacceptable movement during complex surgery
- Failure to achieve essential interventions including:
Failure to intubate
- Misplacement of a tracheal tube



2-12

“OK, Bernice. He no longer seems to feel your punches. The Novocain seems to have kicked in.”

Negligent adverse events related to anaesthesia

Inappropriate technique including:

- No rapid sequence induction despite indications
- Adverse drug reactions after a previous episode (known or unknown previously)

Complications of positioning including:

- Compartment syndrome: focal or limb
- Neurological injury
- Skin injury
- Ophthalmic injury

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"Sure we're underfunded, but we manage!"

Negligent adverse events related to anaesthesia

Failure to ensure physiological stability including:

- Ventilation
- Oxygenation
- Oxygen delivery
 - Circulating volume
 - Haemoglobin
- Temperature
- Coagulation status
- Biochemistry
- Adequate BP

Negligent adverse events related to anaesthesia

Errors

- Consent
- Drug administration error
- Delay in intervention
- Misdiagnosis and inappropriate treatment
- Deviation from appropriate treatment algorithm

Failure to respond appropriately to recognized complications of anaesthesia Cannot intubate, cannot ventilate

- Difficulty in ventilation
- Anaphylaxis
- Malignant hyperpyrexia, etc.

The Vulnerability Scale

Every anaesthetist /Pain nurse must be aware of the risks associated with the primary aims of anaesthesia/analgesia, namely :

- achieve and maintain anaesthesia (or effective pain relief)
- provide anaesthesia and prevent awareness
- be competent in technical procedures such as intubation, invasive monitoring, and regional techniques. E.g. what to do in can't intubate, can't ventilate scenario.
- Practice safe patient positioning
- Practice safe Post op care
- Obtain informed consent
- Seek authorization where required

Any shortfall that results in an adverse outcome is probably indefensible

Avoiding Litigation

Pragmatic guidance from the defence organizations has not changed markedly in recent years and recommendations to avoid litigation from over a century ago still stand:

- 'Good record keeping essential
- Given an honest prognosis, along with the diagnosis
- Careful interpretation of X-rays
- Seek specialist opinions from others
- Don't openly criticize colleagues
- Don't take on cases beyond abilities
- Written consent from patients of dubious character
- Anaesthetics should not be given to women without a female present'

A FINAL THOUGHT

- “There are very few professional men who will assert that they have never fallen below the high standards rightly expected of them. That they have never been negligent.....What distinguishes Mr Jordan from his professional colleagues is not that on one isolated occasion his knowledge and skill deserted him, but that damage resulted”

Lord Donaldson in Whitehouse v Jordan.

Summary

- Healthcare litigation is increasingly common, and represents a significant cost in healthcare expenditure.
- The majority of claims are never made available to clinicians for educational purposes, and do not inform future practice. This may represent a significant missed opportunity.
- Standards of care that would be judged unsatisfactory are not clearly defined. This lack of clarity increases the risk of successful litigation (and patient harm).
- A coordinated approach to the collation of medico-legal cases could enhance anaesthetic practice and patient safety, while reducing the financial burden of healthcare litigation.



If The NHS Hands You A Lemon

DEPRESSED?

OVER WORKED?

JOB SUCK?

UNAPPRECIATED?

FAMILY PROBLEMS?

MONEY WORRIES?

Well Here is a pill for YOU!

FUKITOL[®]
1000mg

**When Life just Blows...
FUKITOL[®]!**



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